Health Insurance Partnership
Clarifying the Scope of the Board Studies
October 24, 2007

Board decisions needed to clarify the scope of the studies and select a consultant

On November 8, 2007, the Health Insurance Partnership Board needs to vote on six recommendations for its preliminary and final studies. The recommendations were drafted to provide the Board with specific options that further clarify the scope of the studies as provided in legislation. These recommendations are presented to the Board now because the Health Care Authority needs to clarify the Board's expectations to prospective consultants who will bid on the studies.

Approval of these, or similar, recommendations will allow the Health Care Authority to issue a request for proposals to prospective consultants soon after the November meeting. The winning consultant will begin work in mid-January 2008, which will allow the Board to complete both studies on time.

The Board's preliminary and final studies

Preliminary study

By December 1, 2008, the Board will submit a preliminary report to the Governor and Legislature that estimates the utilization of health care services and the cost of coverage when Washington's Individual and Small Group markets are incorporated in the Partnership. The preliminary study is described in Section 10 of E2SHB 1569 which specifies that the report will include an implementation plan for incorporating both markets into the Partnership.

Finally, the Board will advise the Governor and Legislature on modifying the Board's membership to reflect incorporating all individual and small group health plans in the Partnership.

Final study

By September 1, 2009, the Board will provide recommendations on adding public-sector markets to the Partnership under an individual mandate. This final study, described in Section 11 of E2SHB 1569, will examine the risks and benefits of the following public-sector markets participating in the Partnership: High Risk Pool, Basic Health Plan, Public Employees' Benefits Board, and public school employees (K-12). The Board will also provide its final recommendations on incorporating all individual and small group health plans in the Partnership.

The study must provide additional advice on the implicit subsidy from pooling non-Medicare-eligible retirees with active employees when the Public Employees' Benefits Board participates in the Partnership. In particular, the impact of any new pooling

arrangement upon Medicare-eligible retirees in the Public Employees' Benefits Board must be examined in the final study.

Again, the Board will advise the Governor and Legislature on modifying the Board's membership to reflect the participation of public-sector markets and the incorporation of all individual and small group health plans in the Partnership.

Recommendations that clarify the scope

Staff developed the following recommendations for the Board to discuss and vote on at the November 8, 2007 meeting. These recommendations clarify the scope of the Board's preliminary and final studies as described in legislation and allow the Health Care Authority to issue a request for proposals.

Recommendations that pertain to both studies

Recommendation #1: A consultant should perform both studies under the Board's direction at an amount not to exceed $600,000, and the Board should delegate the responsibility for completing the request for proposals and consultant selection to Steve Hill, Chair of the Board, and Administrator of the Health Care Authority.

Modeling extensive reforms to Washington's health care system is a job best performed by an experienced consultant with the ability to guide the Board's development of both studies and the knowledge to advise the Board on making recommendations. Staff arrived at the recommended amount, not to exceed $600,000, by comparing the cost of similar studies performed in Massachusetts, New Mexico, and Wisconsin.

The Health Care Authority will monitor the consultant's progress and ensure that the consultant will produce preliminary and final studies that meet the expectations of the Board. The consultant will advise the Board directly and assist the Board in specifying policies and developing assumptions to be studied. The consultant will also provide analytic interpretations that help the Board develop conclusions and any recommendations. Appendix A highlights the type of statistical analyses the Board can expect from a consultant.

Reaching agreement on the recommendations that follow will provide the necessary guidance to the Health Care Authority and its Administrator, Steve Hill, to issue a request for proposals and select the Board's consultant. Should a problem arise that only the Board can resolve, then Mr. Hill will refer the issue to the Board for a decision.

Recommendation #2: Both reports should study one market within the Partnership.

The private and public-sector markets to be included in the Partnership should be studied as one market. For example, the preliminary study should examine a Partnership where carriers offer individuals and small groups the same set of health plans through one market. Carriers would rate premiums based upon the medical experience of their Partnership enrollees. Individuals and small groups would not purchase health plans outside of the Partnership. Similarly, the additional public sector markets should become part of the Partnership's sole market when analyzed in the final study.

By studying these private and public enrollees in one market, the Board will examine the central question that surfaced when House Bill 1569 was introduced in the 2007 legislative session: What happens to the cost and enrollment of various private and public markets when they are offered exclusively through the Partnership?

The Board will still have the option of evaluating different eligibility and rating policies within the Partnership's single market. For example, the consultant should be able to model different rating mechanisms that more closely resemble experience rating or pure community rating. The impact of different risk management methods such as reinsurance, risk adjustment, or risk pools can also be modeled.

Recommendation #3: Both studies should evaluate the Partnership's impact upon Association Health Plans and the Preliminary study should evaluate the Partnership's impact upon the Basic Health Plan.

To fully evaluate the impact upon small employers and low-income individuals, the Board should study the impact of the Partnership on Association Health Plans and the Basic Health Plan:

> About 300,000 small-employer enrollees purchase insurance through the Small Group market and it has been estimated that about that many enrollees are also covered through association health plans. Because association health plans are offered through Washington's Large Group market, they will not be included in the Partnership for purposes of the preliminary or final study. So, the Board cannot fully evaluate the cost and uptake of coverage by small employers unless the consultant evaluates the impact of the Partnership upon coverage in association health plans.
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> The Basic Health Plan subsidizes individual coverage for about 100,000 enrollees in a standardized health plan. The preliminary study includes the entire Individual market in a Partnership that offers choice and subsidies. So, the Board should weigh the potential impact upon Basic Health Plan enrollment. (In the final study, the Basic Health Plan will be analyzed within the Partnership.)

Recommendations that pertain only to the preliminary study

Recommendation #4: The implementation plan in the preliminary report should analyze major barriers and key operational decisions.

At this point, an implementation timeline with detailed tasks and dates will not inform policy-makers who are weighing whether to combine the Individual and Small Group markets. But, the decision to incorporate the Individual and Small Group markets in the Partnership can benefit from a detailed examination of key implementation barriers and how they might be overcome. Advice on important operational decisions, areas of the Partnership that must be expanded or developed, and in what order and how long it will take to perform the tasks is needed. If Washington decides to incorporate these two markets in the Partnership, then a detailed implementation timeline will be needed.

Recommendations that pertain only to the final study

Recommendation #5: The final report should study an individual mandate that achieves universal or near-universal coverage and the Board should study no more than three options that apply the mandate.

An individual mandate is intended to make a minimum level of health care benefits available to each person. Applying an individual mandate to Washington's current health care system would not likely achieve universal or near-universal coverage. To effectively study an individual mandate, the Board will need to specify health care system reforms that accommodate and support the mandate.

The consultant will guide the Board's study of reforming Washington's health care system. For example, the Board might choose to specify or modify the policies and programs published by the Blue Ribbon Commission on Health Care Costs and Access and later passed in E2SSB 5930. The Board might need to discuss additional policy considerations that support coverage such as:

- What lower-cost plans need to be offered, if any?
- Should separate health plans be offered to young adults and what type of plans are needed?
- What administrative improvements are needed, if any?
- Should Medicaid or Basic Health enrollment be expanded, and if so, to what income levels?
- Should a minimum level of employer financing be required, and if so, now much?

Finding common ground on a health care reform proposal for the study might prove to be challenging, and so the Board may want to specify multiple options. However, the Board must limit its options so that prospective consultants can bid a price for the studies. No more than three options would allow the Board to study traditional and innovative options of an individual mandate.

Recommendation #6: In the final study, the risks and benefits of an individual mandate should be studied in terms of cost, quality, and access.

In the final report, the Board is directed to provide recommendations on the risks and benefits of establishing an individual mandate for coverage. The risks and benefits of most health care issues can be analyzed in terms of cost, quality, and access – a format easily recognized by policy-makers.

The Board is working under a tight timeline to issue the request for proposals, and so please inform Lynn Kennedy before the November Board meeting at (360) 923-2829 or Lynn.Kennedy@hca.wa.gov if you have serious concerns about any of these recommendations. Also, please contact Lynn with any questions, clarifying comments, or additional recommendations the Board should consider at the meeting.

Appendix A: Analysis of utilization, coverage, and an individual mandate

This appendix highlights the type of statistical analyses a consultant is likely to perform for both studies.

Utilization of health care services

The consultant should estimate the *utilization of health care services* under a Partnership with additional private and public enrollees, and then compare those estimates with current statistics in each of the private and public markets studied:

- Total and per person cost of health care services.
- Cost of utilization in settings of care such as hospitals, office-based medical care, and prescription drugs.
- Key features of the Partnership such as choice, subsidies, or the designated health plans and how they impact cost, quality, or access to health care services.

Cost of coverage

The consultant will also estimate the *cost of coverage* under a Partnership with additional private and public enrollees, and then compare those estimates with current statistics in each of the private and public markets studied:

- Total and per person cost of coverage.
- The total cost of coverage broken down by health care services and administrative expenses.
- The total cost of coverage broken down by premium and out-of-pocket expenses.
- The change in the cost of coverage due solely to merging the medical experience of different markets, which includes the uninsured.
- The breakdown of private and public expenditures within the Partnership; whether state subsidies replace private premium dollars (referred to as “crowd-out”) under the Partnership should also be estimated.
- How changes in the cost of coverage impact current enrollment and the uninsured.
- Key features of the Partnership such as choice, subsidies, or the designated health benefit plans and how they impact the cost of coverage, administrative expenses, premiums, or out-of-pocket spending.
- Medical loss ratios (total health care expenses divided by total plan premiums) in the Partnership should be estimated and compared to coverage in the current private-sector markets.

Individual mandate

The study will begin by calculating the costs and enrollment of Washington's current health care system, and then analyze the Board's individual mandate options specified for the final study:

- Estimate private and public sources of funds, expenditures, and enrollment.
- Highlight the impact of an individual mandate on the uninsured, uncompensated care, administrative expenses, and trends for premium and out-of-pocket spending.
- Evaluate legal issues and provide advice on enforcement.
- Estimate the socioeconomic benefits of coverage, e.g., will coverage provide for a better quality of life or more economic productivity?
- Estimate the impact upon the economy, e.g., changes in wages or employment.